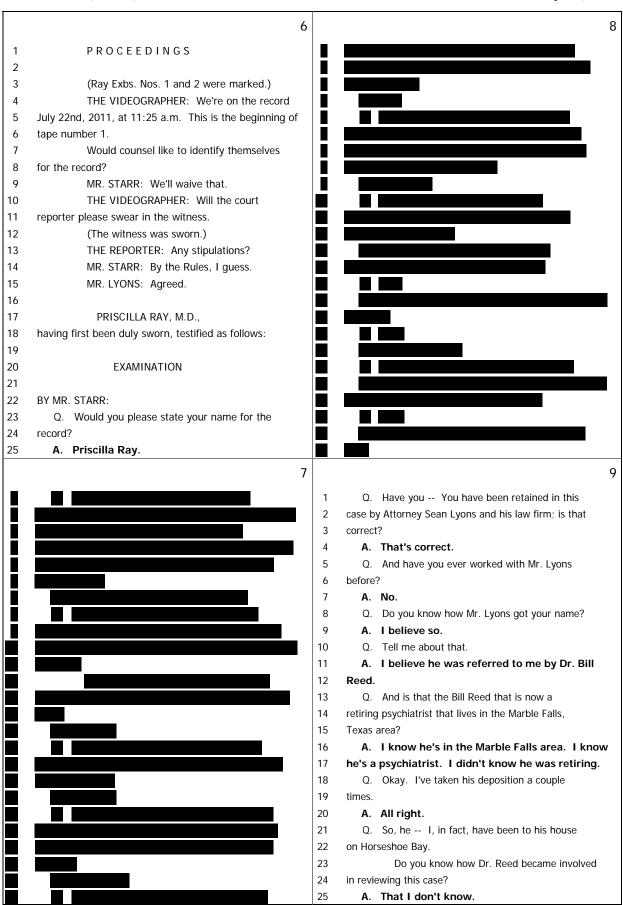
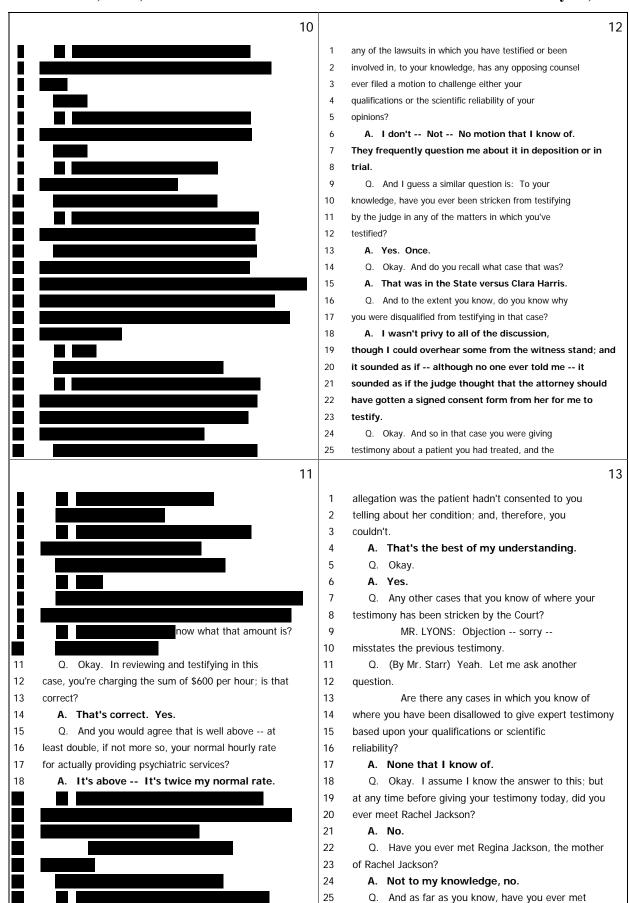
LOK THE MESTER	RN DISTRICT OF TEXAS
AUST	IN DIVISION
	:
REGINA JACKSON AND RUDOLF	:
WILLIAMSON, INDIVIDUALLY,	:
AND ON BEHALF OF THE ESTA	re :
OF RACHEL JACKSON, DECEASI	ED,:
Plaintiffs,	:
	:
VS.	: CA NO. A 10 CA 522 22
	:
JOHN S. FORD, M.D., AND	:
TRAVIS COUNTY, TEXAS,	:
Defendants.	:
	:
	:
ORAL AND VIDEOTAPED DEPO	OSITION OF PRISCILLA RAY, M.D.
	OSITION OF PRISCILLA RAY, M.D.
JULY	
JULY ORAL AND VIDEOTAPED I	Y 22, 2011 DEPOSITION OF PRISCILLA RAY,
JULY ORAL AND VIDEOTAPED I M.D., produced as a witnes	Y 22, 2011 DEPOSITION OF PRISCILLA RAY,
JULY ORAL AND VIDEOTAPED I M.D., produced as a witnes Defendant John Ford, M.D.	Y 22, 2011 DEPOSITION OF PRISCILLA RAY, ss at the instance of the
JULY ORAL AND VIDEOTAPED I M.D., produced as a witnes Defendant John Ford, M.D. the above-styled and numbe	Y 22, 2011 DEPOSITION OF PRISCILLA RAY, ss at the instance of the , and duly sworn, was taken in ered cause on Friday, July 22,
JULY ORAL AND VIDEOTAPED I M.D., produced as a witnes Defendant John Ford, M.D. the above-styled and number 2011, from 11:25 a.m. to	Y 22, 2011 DEPOSITION OF PRISCILLA RAY, ss at the instance of the , and duly sworn, was taken in ered cause on Friday, July 22,
ORAL AND VIDEOTAPED I M.D., produced as a witnes Defendant John Ford, M.D. the above-styled and number 2011, from 11:25 a.m. to	DEPOSITION OF PRISCILLA RAY, ss at the instance of the , and duly sworn, was taken in ered cause on Friday, July 22, 4:23 p.m., before Mary C. and Reporter No. 463 and Notary
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	A P P E A R A N C E S	1	RAY EXHIBITS (CONT'D.) PAGE
2	COUNTY FOR BLANKING	2	Exhibit 6
	COUNSEL FOR PLAINTIFFS:	3	New FDA Warning about fatal risk lined to
4	Mr. Sean M. Lyons		Melaril after 40 years (1 page)
	Hendersonlaw, P.C.	4	08-18-2000 Psychiatric News FDA Approves New
5	1301 W. 25th Street, Suite 400		Warnings for Thioridazine, Valproate (2 pages)
	Austin, Texas 78705	5	Thioridazine Official FDA information, side
6	Telephone: 512/439-3200 Fax: 512/439-3201		effects and uses (4 pages)
	E-mail: slyons@hendlerlaw.com	6	. 1 3 /
7		7	Exhibit 7 62
8		8	Documentation of visual observations, including
	COUNSEL FOR DEFENDANT JOHN S. FORD, M.D.:	"	all unusual, pertinent and clinical events for
9	,,,	9	
	Mr. Paul Byron Starr	1	7/16 1609 through 07/18 1345 (2450125 - 2450127
0	Germer Gertz Beaman & Brown, LLP	10	E-l-ll-lt-0
	301 Congress Avenue, Suite 1700		Exhibit 8 62
1	Austin, Texas 78701	11	
	Telephone: 512/472-0288 Fax: 512/472-0721		Open Psych Status Notes (2450136)
2	E-mail: pstarr@germer-austin.com	12	
	E-mail. pstarr@germer-austin.com	13	Exhibit 9 86
3	COLUNIOSI, FOR RESENDANT TRAVER COLUNTY, TEVAS	14	Curriculum Vitae Revised 12/04 (4 pages)
	COUNSEL FOR DEFENDANT TRAVIS COUNTY, TEXAS:	15	
5	Ms. Elaine A. Casas		Exhibit 10
	Ms. Jennifer Kraber	16	100
6	Travis County Attorney	10	Novartic manufacturor's literature for Melleril
	314 West 11th Street	4-	Novartis manufacturer's literature for Mellaril
7	Granger Building, Suite 420	17	and Mellaril-S (15 pages)
	Austin, Texas 78701	18	
3	Telephone: 512/854-9513 Fax: 512/854-4808		Exhibit 11 191
-	E-mail: elaine.casas@co.travis.tx.us	19	
9	jennifer.kraber@co.travis.tx.us		11/1996 Clinical Pharmacology & Therapeutics
	Jenniler.kraber@co.travis.tx.us	20	article, "Concentration-related pharmacodynamic
)	DEDODTED BY: VIDEO BY:	-	effects of thioridazine and its metabolites in
	REPORTED BY: VIDEO BY:	21	humans" (13 pages)
	Mary C. Dopico, CSR, RPR, CRR Richard Rienstra	1	numans (13 pages)
	Independent Contractor To:	22	Eulaille is 10
	Wright, Watson & Associates		Exhibit 12 191
3	Firm Registration No. 225	23	
	Expires 12-31-2011		03/1991 Clinical Pharmacology & Therapeutics
	3307 Northland Drive, Suite 185	24	article, "Plasma levels of thioridazine and
	Austin, Texas 78731		metabolites are influenced by the debrisoquin
	512/474-4363 Fax 512/474-8802	25	hydroxylation phenotype" (8 pages)
	3		
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	PAGE		"Pharmacokinetic Interaction of Fluvoxamine
	Appearances 2	4	and Thioridazine in Schizophrenic Patients"
ļ	Proceedings/Stipulations6		(7 pages)
	Changes and Signature Page 215	_	(7 pages)
5	Reporter's Certification	5	
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)	Exhibit 2	15	the mid-Nineties
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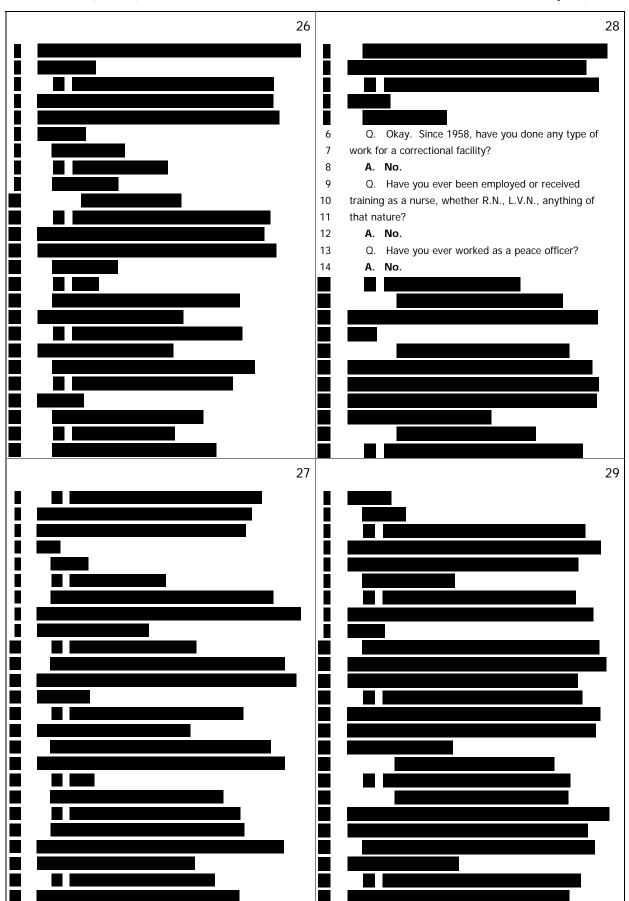


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3 (Pages 6 to 9) EXHIBIT F

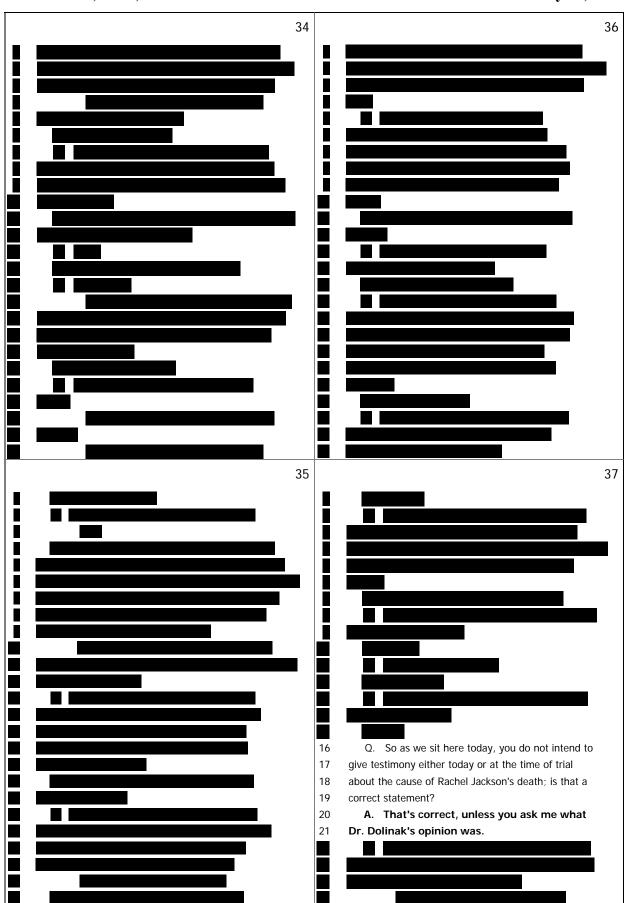


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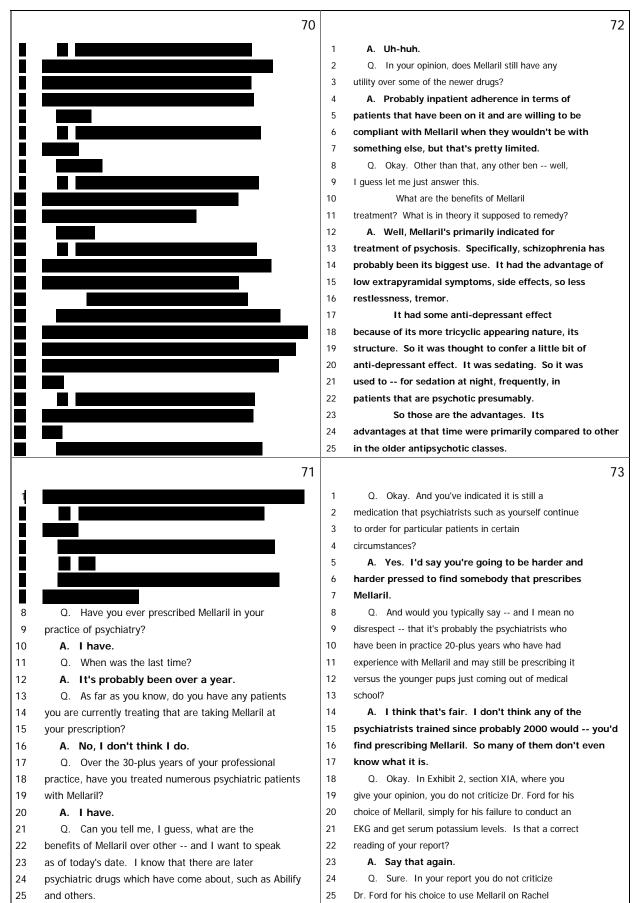


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8 (Pages 26 to 29) EXHIBIT F



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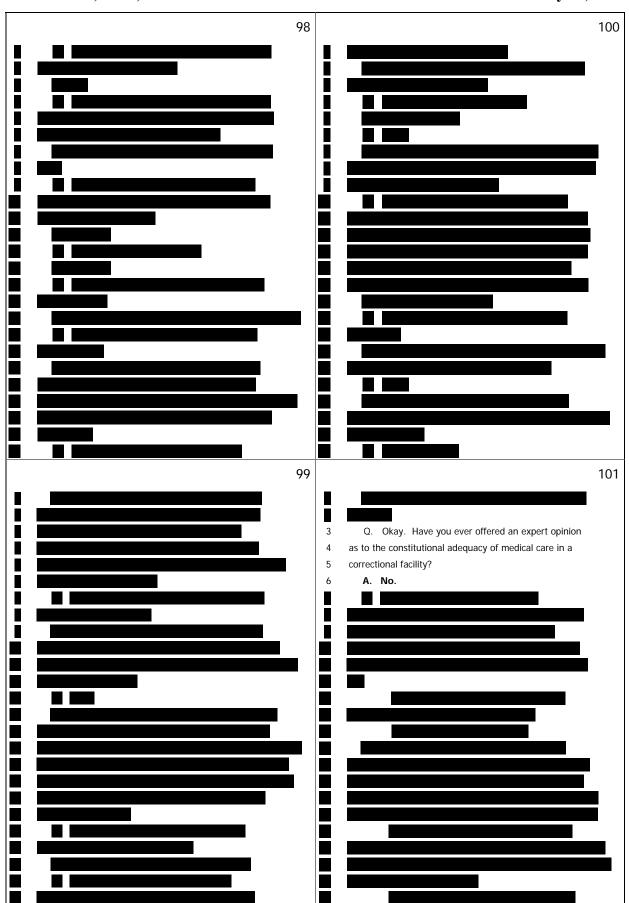


	74		76
1	Jackson but only you're critical of the fact that he did	1	third antipsychotic medication to the patient's regimen.
2	not get an EKG or serum electrolyte levels. Is that a	2	You now have the side effects and
3	correct reading of your report?	3	potential toxic effects of three different medicines.
4	A. That's pretty much what my report says.	4	Q. But you agree that it's not a good idea
5	Uh-huh.	5	typically to simply stop cold turkey, in this case
6	Q. Okay. And is that the way you feel today? Do	6	specifically, either the Abilify or Risperdal but, in
7	you wish to expound on that or change your opinions in	7	fact, to start the third medication and then slowly wean
8	that regard?	8	the patient off one of those two?
9	A. It's a it is not exactly a change. And I	9	MR. LYONS: Objection, states fact not in
10	debated about this when I first read that. I'm not sure	10	evidence.
11	it falls below the standard of care to prescribe	11	A. If If you think one of If you think
12	Mellaril. That's why I don't comment at all on it	12	those aren't working and you're planning to stop one of
13	there.	13	them, you don't really have to wean them particularly.
14	I think a better choice might have been	14	They can be stopped.
15	to maximize one of the other two, which may be a little	15	Q. (By Mr. Starr) Okay.
16	less likely to cause arrhythmias and other problems; and	16	A. So, as I say, I can't say that that falls
17	neither one of those two was maximized in terms of	17	below the standard of care. It's but then you asked
18	dosage.	18	me the question am I critical. The answer is I'm
19	Q. Okay.	19	critical, but I don't think it fell below the standard
20	A. So rather than add a third antipsychotic with	20	of care.
21	yet more side effects, I think I would have preferred to	21	Q. Okay. Dr. Ford prescribed this patient 100
22	see one of the other two maximized. But I'm not sure	22	milligrams of Mellaril on July 18th, 2008 to be taken
23	that falls below the standards of care, and so I just	23	one time at night. Is that your understanding?
24	left that out.	24	A. Yes.
25	Q. Okay. And so	25	Q. And it is my understanding from reviewing the
	75		77
1	A. But your question was, was I critical? Yes,	1	medical literature that kind of the typical starting
2	but not below the standard of care.	2	dose can be as much as 100 milligrams three times a day.
3	Q. Okay. So So perhaps to summarize, you	3	Is that your understanding?
4	might have done it differently; but you don't believe he	4	A. Yes, if it's being prescribed for psychosis.
5	breached the standard of care in prescribing Mellaril	5	Q. And so based upon which would be a total of
6	for this patient.	6	300 milligrams; right?
7	A. I think, yes, I probably would have done it	7	A. Right.
8	differently; and I think most people trained today would	8	Q. And so based upon that, would you agree that
9	likely do it differently who have been taught to	9	Dr. Ford's prescription for Mellaril for this patient on
10	maximize the dose of one or two at most antipsychotics.	10	July 19th was a fairly low prescript dosage compared
11	But I agree I don't I can't say that it fell below	11	to what, I guess, was allowed by the dosage parameters?
12	the standard of care. So I'm not going to say that.	12	A. If Mellaril were the only drug being
13	Q. And did you read Dr. Ford's deposition	13	prescribed, that would be true.
14	testimony where he indicated his intent was over the	14	Q. Okay. And based upon the other drugs that
15	next few days to actually wean the patient off of one or	15	were being prescribed, would you still say that 100
16	both of the other medications	16	milligrams of Mellaril prescribed by Dr. Ford on July
17	A. Uh-huh.	17	18th was a relatively low dosage of Mellaril?
18	Q she was taking?	18	A. If you are looking at dosage ranges for
19	A. Yes.	19	Mellaril, yes.
20	Q. And in your opinion, is that a reasonable	20	Q. Okay.
21	thing to do; or would that have been a reasonable course	21	A. There is the consideration that you have a
	· ·	22	patient on other antipsychotics that is not addressed by
22	of action?		
22 23	A. It would be reasonable to wean one of the	23	Mellaril dosage recommendations.
			Mellaril dosage recommendations. MR. STARR: I'll object to the

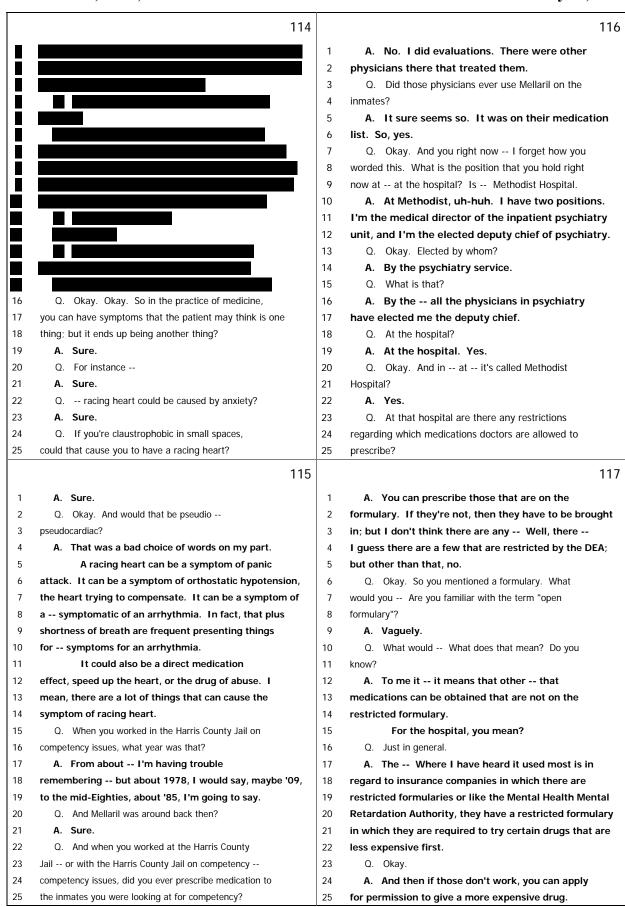
90	92
1 Q. Okay.	1 A. More acutely, yes.
2 A. I kind of got caught up in those two, but	2 Q. What do you mean by "more acutely"?
3 that's it.	3 A. Well, you know, she's If you have an
4 Q. Okay. And in your earlier testimony, you	4 increase in cerebrospinal pressure sufficiently from,
5 talked a little bit about some things that could cause	5 say, a herniation of the brain, what you do is to wedge
6 arrhythmias in some patients. Can the use of cannabis	6 the breathing center, in essence, of the brain down into
7 cause a heart arrhythmia?	7 a smaller opening; and you can cause death that way.
8 A. There's There are some reports of that.	8 The increase in cerebrospinal fluid
9 There are The answer is there are some reports of	9 causes something not usually stopping breathing but
10 that. I haven't actually seen patients that are doc	10 might cause, for example, incontinence, trouble walking,
11 have been documented to have cardiac arrhythmias because	11 trouble thinking, things like that, depending upon where
12 of it .	12 the pressure manifests.
13 Q. But you said there have been some reports of	13 Q. Okay. And are you aware that Rachel Jackson
14 the use of can cannabis causing arrhythmias and some	urinated on herself at the time that she was arrested?
15 fatal; is that correct?	15 A. Yes.
16 A. I believe I remember that some could be fatal.	16 Q. And can just the use of Mellaril alone cause a
17 As, again, I haven't seen that, so	17 fatal heart arrhythmia?
18 Q. And did you see what Ms. Jackson's cannabis	18 A. It certainly is known to cause arrhythmias
19 toxicology levels were after her death?	19 which can be fatal.
20 A. Yes. I don't remember what they were; but I	20 Q. And the use of Risperdal alone?
21 saw them, yes.	21 A. Yes, it certainly can cause arrhythmias, as
22 Q. Do you think that they were something that	22 well.
23 would be considered high cannabis levels post-mortem?	23 Q. I'm going to kind of back up a little bit; but
24 A. I think Dr. Dolinak testified to that. I'm	going to the exhibit that is your list of cases
25 not sure what post-mortem ones are, how quickly it	25 that's Exhibit 4, I believe.
91	93
1 declines	
	· ·
2 Q. Okay. 3 A if it does or if it's degraded post-mortem.	 Q. In any of these cases, did you have to participate in any hearings where your testimony was
	4 attempting to be limited in scope?
4 Q. Okay. And low potassium can also cause fatal 5 arrhythmias?	5 A. What do you mean?
6 A. Yes.	6 Q. Have you ever been told by a court in one of
7 Q. And I think Mr. Starr talked to you a little	these cases that your you shouldn't testify about
,	,
9 the arachnoid cyst, could that possibly cause a fatal 10 arrhythmia?	·
	, , ,
11 MR. LYONS: Objection, foundation.	•
12 A. I think that's unlikely. 13 O (Ry Ms Casas) Okay. Do you know anything	12 opinions on.13 Q. Uh-huh. Yes.
13 Q. (By Ms. Casas) Okay. Do you know anything	
 about brain cysts like the ones that Rachel Jackson had? MR. LYONS: Objection, vague. 	• •
, , ,	15 Q. You have never had participated in any kind
16 A. I know some. I mean, I'm not a neurosurgeon;	of a hearing on a motion to strike a part of your
17 but	 testimony? A. I've been asked in court sometimes by the
18 Q. (By Ms. Casas) Okay.	•
19 A I've had patients who've had cysts.	judge. I've been asked questions, more commonly in
20 Q. You've treated patients who have had cysts?	20 federal court, about my testimony and what it entails.
3 3	
	· ·
·	, ,
A. Uh-huh. Sure. O. And can a cyst in your brain affect the pressure of the cerebrospinal fluid in your brain? A. It can. It depends on where it is. O. And can that cause somebody to stop breathing?	 Is that what you're asking me? Q. Yes. A. Okay. Q. And has a judge ever instructed you to lir your testimony to a certain area?

24 (Pages 90 to 93) EXHIBIT F

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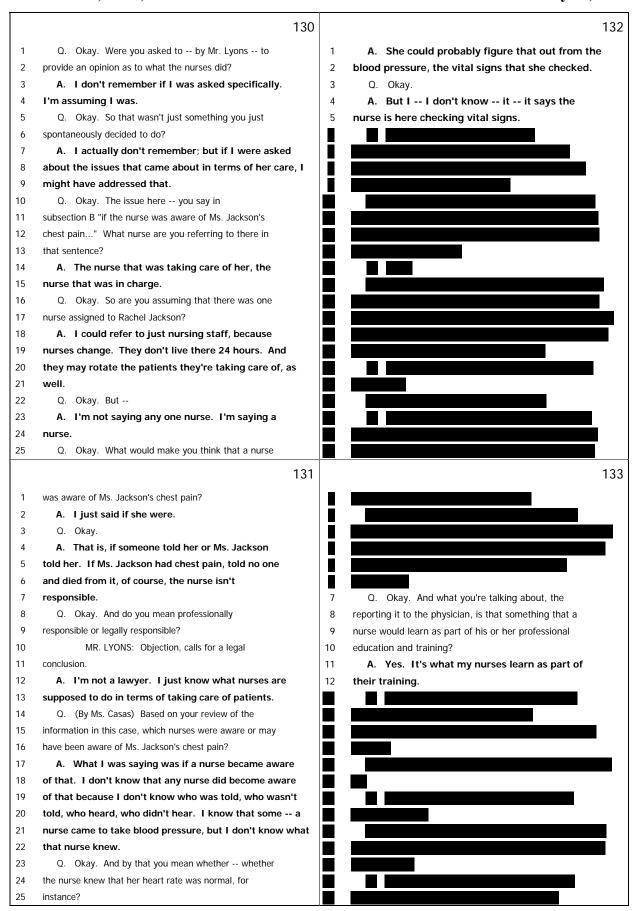
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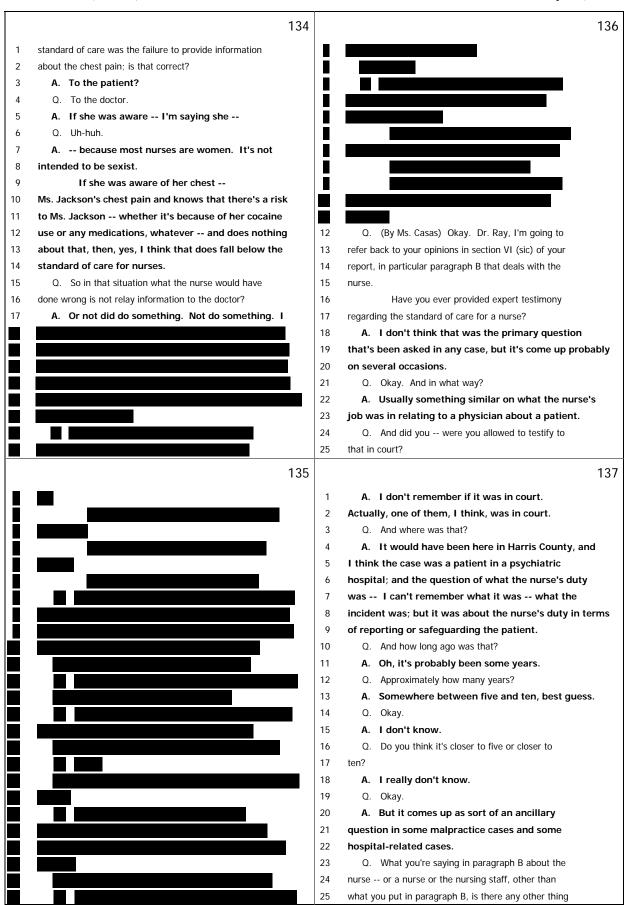


	118		120
1	Q. Do you-all have a formulary at the Methodist	1	you've checked potassium levels?
2 H	ospital?	2	A. No. As I said, there there are going to be
3	A. We do.	3	very few things in a hospital, which is not in the
4	Q. And are there drugs that aren't on the	4	practice of medicine, is going to tell a doctor that
5 fo	ormulary that doctors are not allowed to use?	5	they must or must not do.
6	A. It's not that they're not allowed to use them.	6	Q. And that would be similar to a jail; correct?
7 It	s's that the hospital doesn't stock them.	7	A. To a jail telling a doctor what to prescribe?
8	Q. Okay. So does the hospital stock Mellaril?	8	Q. Right. That wouldn't make any sense; would
9	A. I haven't even looked recently because no	9	it?
10 o ı	ne's prescribed it since I did about a year ago.	10	A. It wouldn't to me. As I said, I've never
11	Q. Okay.	11	prescribed anything in a jail; but I can't imagine that
12	A. So I haven't looked. There was a	12	a jail would tell me how to practice medicine.
13 r e	ecommendation for removing it, and I think at that time	13	Q. Right. Okay. Do you know if you've had any
	ne discussion was let's leave it a little while longer.	14	deaths at Methodist Hospital that were attributed to the
	don't know since then. I'm not on pharmacy and	15	use of Mellaril or Risperdal?
	nerapeutics.	16	A. I don't The man that died as a result of
17	Q. Okay. So there is nothing, as far as you	17	Mellaril overdose some years ago, I believe, was at
	now, that would prevent a doctor at Methodist Hospital	18	Methodist. I can't remember if he was at Methodist or
	om prescribing Mellaril to a patient?	19	St. Luke's, but that was thought to be due to a Mellaril
20	A. No, I don't think so. I think you could	20	overdose. And he died with a cardiac arrhythmia they
	robably even bring it in from outside if it were	21	couldn't correct.
•	rought in from an outside pharmacy, investigated by the	22	Q. And an overdose is different than what
	harmacy department and relabeled.	23	happened or allegedly happened to Rachel Jackson in this
24 24	Q. Are there any requirements on the doctors at	24	case; correct?
	ne Methodist Hospital to perform ECGs before giving	25	A. Right.
	119		12'
	117		12
1 M	lellaril?	1	Q. And what's the difference?
2	MR. LYONS: Objection, foundation.	2	A. Is that he took more than was prescribed.
3	Q. (By Ms. Casas) And I'm asking by the	3	Q. And what was the problem with Rachel Jackson
4 h	ospital, not by the FDA.	4	as opposed to that other one?
5	A. No. I don't think the hospital would tell you	5	A. She
	hat you have to do to prescribe a medication. I mean,	6	MR. STARR: Objection, vague and
7 I	would of course, have taught the residents to do	7	ambiguous.
8 t	nat; but	8	A. Yeah. She As far as we know, she didn't
9	Q. So, basically, they could prescribe Mellaril	9	take an overdose of Mellaril.
10 ar	nd then use their education, training and experience to		
11 de	etermine what would be necessary to do before giving		
12 th	ne Mellaril?		
13	A. "They," talking about the residents?		
14	Q. (Nods head affirmatively.)		
15	A. They could. They'll see me next year, as		
16 w	vell, doing the rotation over.		
17	Q. Right. And for doctors at the hospital, also?		
18	A. Yes. There's no In the vast majority of		
19 e	vents that take place in the hospital, there is not		
20 g	oing to be someone saying you must do it this way.		
21 T	hat's what the doctor is for, is to assess the patient		
22 a ı	nd to know what risks there are and to attend to those.		
23	Q. And what about potassium levels? So there's		
24 no	o instructions to doctors at Methodist Hospital		
25 al	bout by the hospital about not using Mellaril until		

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	100		104
	122		124
1	Q. (By Ms. Casas) Is it unique to each	1	that. I believe I was one of several people back in,
2	individual? I mean, could the same dosage and	2	I'm going to say, maybe the early Eighties when there
3	combination of medications be safe in one individual but	3	were some lawsuits about the Texas Department of
4	not safe in another?	4	Corrections. It was, I don't know, like a consortium of
5	MR. LYONS: Objection, compound.	5	people that of psychiatrists that were discussing
6	A. I don't know about safe. It might not cause	6	psychiatric care within in the prison system.
7	problems	7	It wasn't testimony. It was a group of
8	Q. (By Ms. Casas) Okay.	8	us that were sort of asked for opinions about the level
9	A in some people. Sure.	9	of care that should be there, what facilities should be
10	Q. Okay. You testified that you worked with the	10	available; and it had something to do with meeting
11	Harris County Jail on competency issues. Do you have	11	federal standards or a federal judge's standards or
12	any specific experience in providing medical care in a	12	something like that.
13	correctional setting	13	Q. Okay. And Was that the Ruiz case?
14	A. No.	14	A. It could have been. I don't know.
15	Q to inmates?	15	Q. That dealt with prisons, not jails; correct?
16	A. I'm sorry. No.	16	A. Right. This was a federal judge overseeing
17	Q. Do you have any specific experience in	17	this, so I'm thinking it was probably a prison system.
18	providing psychiatric care in a correctional setting to	18	Q. And do you know whether there is a difference
19	inmates?	19	in a prison or a jail?
20	A. I consider that a subset of medical care, yes.	20	A. Yeah. There is I know there is a
21	Q. Okay. So the same answer then?	21	difference, but I thought you asked me in correctional
22	A. Same answer.	22	facilities.
23	Q. Okay. And, again, I can assume you have not	23	Q. Yes, I have been. Now I'm asking a different
24	published any articles on the provision of medical care	24	question.
25	in a correctional setting?	25	A. Okay.
	123		125
1	A. That's true. As I say, I publish as little as	1	Q. You're saying in the case where you
2	possible.	2	consulted
3	Q. Okay. And let's talk about nursing. Well,	3	A. Yes.
4	have you ever been a nurse?	4	Q that was about a prison; correct?
5	A. No.	5	A. I'm pretty sure it was.
6	Q. Have you ever gone through training that	6	Q. Okay.
7	nurses go through?	7	A. Because it was people that were there for a
8	A. I've never been to nursing school.	8	while, for a long time.
9	Q. Okay.	9	Q. Okay. So those would be people who have been
10	A. Some of their training is coincident with ours	10	convicted of crimes and are serving their sentence.
11	in some areas.	11	A. I think so. Again, it's very vague to me
12	Q. Okay. Have you Do you have any specific	12	since there were a group of us that were asked to just
13	experience with providing nursing care in a correctional	13	comment on that, so
14	setting?	14	Q. Okay. Again, like Mr. Starr, I hate to ask
15	A. No.	15	you; but have you ever been sued for malpractice?
16	Q. Do you know what is constitutionally required	16	A. Yes. I was sued once.
17	regarding medical care in a correctional setting?	17	Q. How long ago was that?
18	A. Constitutionally required? No.	18	A. That was probably in the I'd say the early
19	Q. And you agree that a jail is not a hospital;	19	to mid-Nineties.
20	correct?	20	Q. Okay. And where was that lawsuit filed?
21	A. Yes.	21	A. Harris County.
22	Q. Have you ever provided any kind of consulting	22	Q. Here in Harris County?
23	services regarding medical care or psychiatric care in a	23	A. Uh-huh. Yeah.
24 25	correctional correctional setting?	24	Q. And what malpractice were you alleged to have
	A. Yes. I'm trying to think of the specifics of	25	committed?



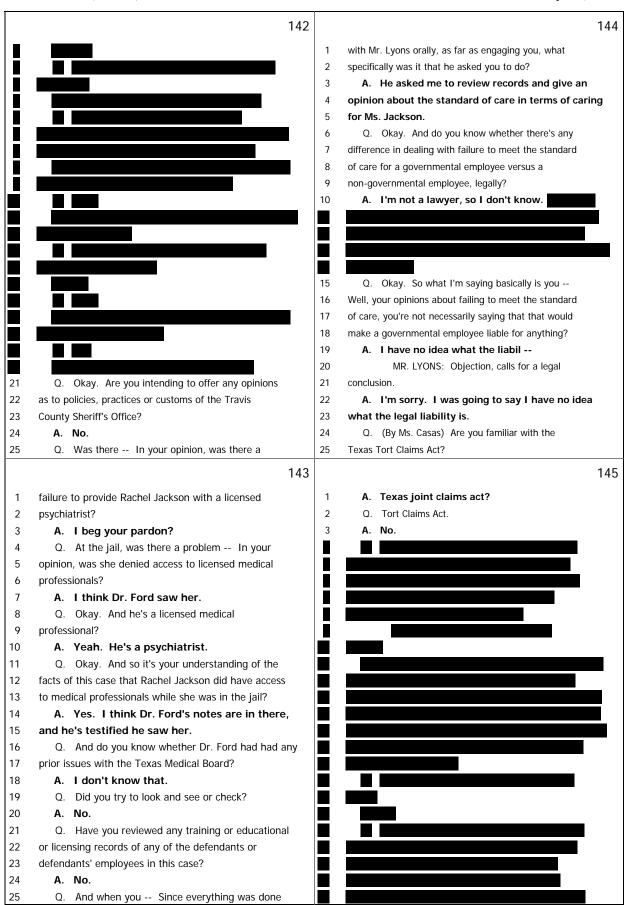


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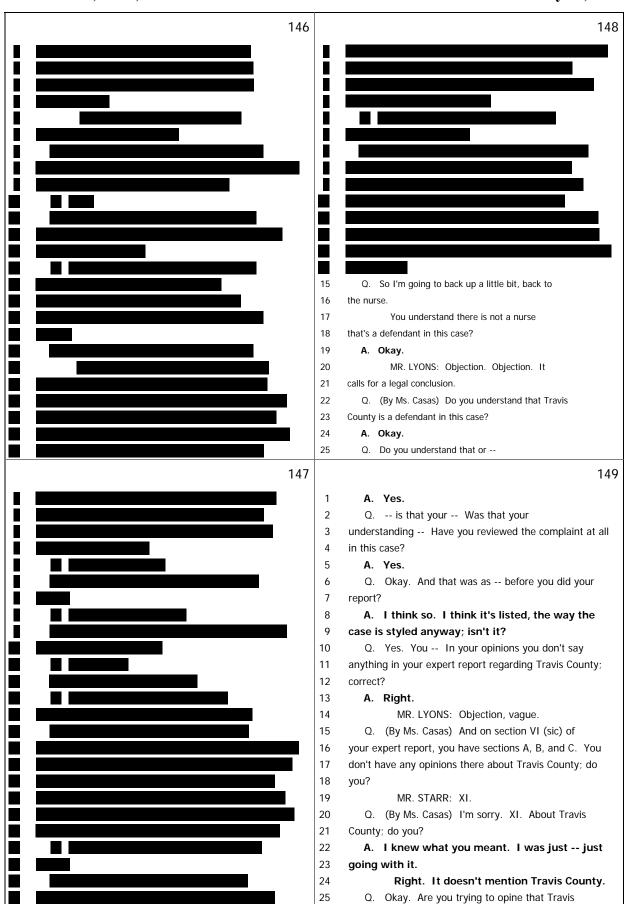
35 (Pages 134 to 137) EXHIBIT F

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	138		140
1	that you believe fell below the standard of care for	1	Q. Do you have any reason to believe or conclude
2	the you know, by the nursing staff at the jail?	2	that a nurse intentionally disregarded a substantial
3	A. I guess it would The answer is it would	3	risk of serious harm to Ms. Jackson?
4	depend, and what it would depend on is whether the	4	A. I don't know, first of all, if they knew of
5	documentation of vital signs is something to which	5	it. I don't know if they knew of the chest pain. So I
6	Dr. Ford or another physician would have had access.	6	can't answer that.
7	Q. Okay. And what do you mean by that?	7	What I said was if they knew and if they
8	A. And I answered that because it's it'll take	8	were aware which I think many nurses working in that
9	me a second to explain.	9	kind of facility, certainly in a psychiatric facility,
10	If that is simply a record that's kept	10	would be aware of the risk of cardiac problems, if
11	somewhere and the physicians don't have access to it and	11	nothing else, with cocaine and with the medications in
12	the next shift of nurses doesn't have access to it, then	12	general then I think it would be problematic.
13	it's really not below the standard of care not to	13	If they didn't know, then they didn't
14	document it because it's not going to make any	14	know.
15	difference at all.	15	Q. Okay. But nothing that neither nurses
16	Q. Okay.	16	actually did Do you have an opinion as to whether
17	A. If it is something that because we don't	17	the nurses at Travis County Jail actually did anything
18	know if they're what they were.	18	to Ms. Jackson that you would consider below the
19	Q. Okay.	19	standard of care?
20	A. It says normal, but we don't know.	20	A. That they did to her?
21	If it is something that Dr. Ford might	21	Q. Uh-huh. Yes.
22	have been able to look at the next day and go, "Pretty	22	A. Do you mean sort of an act of commission? No.
23	normal, but look at that tachycardia. That's quite a	23	Q. Okay. Yes, as opposed to omission.
24	bit different from what it was before." Or the next	24	A. Uh-huh. Yes.
25	shift of nurses might have said, "That That blood	25	Q. Okay. Do you Are Do you intend to
	139		141
1	pressure is really off. I'm going to go check it	1	offer any opinions on whether the actions of Travis
2	again." Then the lack of documentation may fall below	2	County's correctional staff relating to Rachel Jackson
3	the standard of care in taking care of the patient. I	3	was at all, do you intend to offer opinions as to
4	can't say with certainty that it was because I don't	4	their actions?
5	know about the access to the records.	5	A. No. I don't know the standard of their
6	Q. Okay.	6	requirements.
7	A. That's why I didn't say anything.	7	Q. Okay. Are you familiar with the type of
8	Q. Do you intend to offer an opinion as to that?	8	training that's required for correctional officers?
9	A. I guess if someone provides me more	9	A. Only vaguely.
10	information about the access to the records and what the	10	Q. Okay. Do you know what's constitutionally
11	vital signs were, I could; but I haven't been asked to.	11	required for training of correctional officers?
12	Q. And you have not put that in your report;	12	A. No.
13	correct?	13	Q. Do you have a contract with Mr. Lyons for
14	A. Right. Uh-huh.	14	expert services in this case?
15	Q. And what you're concerned with primarily is	15	A. A contract? Do you mean something signed?
16	the sharing of information and documentation; correct?	16	Q. Yes.
17	MR. LYONS: Objection, vague.	17	A. No.
18	A. About that? Yes.	18	Q. A written contract?
19	Q. (By Ms. Casas) About the nurses.	19	A. No.
20	A. About that incident, yes. That's what I'm	20	Q. Everything was done orally?
21	concerned about.	21	A. Yes.
22	Q. Okay. Anything other than issues dealing with	22	Q. Okay.
23	documentation or sharing information with the physician	23	A. Except for the check he wrote.
24	that you believe the nurses did wrong?	24	Q. Okay. And the fee that you're charging
	A. I'm not aware of anything else, no.	25	Mr. Lyons is your customary fee for expert testimony?



37 (Pages 142 to 145) EXHIBIT F

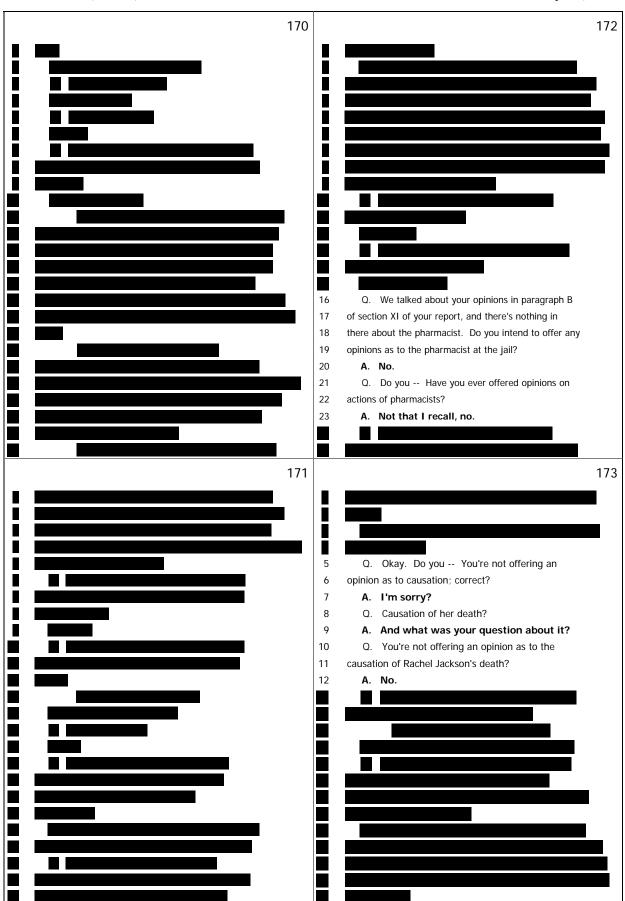


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	150		152
1	County is somehow responsible for Dr. Ford's behavior?	1	A. Enough to call someone if that happens.
2	A. I don't know what Dr. Ford's relationship with	2	Q. Okay.
3	Travis County is or isn't.	3	A. Yes. The answer is no. I don't deal with
4	Q. Okay.	4	that in psychiatry.
5	A. So I have I could comment about	5	Q. Okay. How would you know if it's happening?
6	physicians. I can comment about nurses reporting to	6	A. Usually if through a consultation or
7	physicians and taking care of patients. I don't know	7	through symptoms causing me to refer someone to a
8	anything about counties.	8	neurologist.
9	Q. Okay. So paragraph B specifically refers to	9	Q. And what kind of symptoms would suggest
10	the nurse or nurses. I'm trying to understand, do you	10	intracranial hypertension?
11	have some kind of a theory that Travis County would be	11	A. Almost any neurological symptoms; and some of
12	responsible for the nurses' actions solely because they	12	those might be gait disturbance, cognitive disturbances,
13	employed them?	13	incontinence.
14	A. I	14	Q. Okay. Can a seizure Can someone die from
15	MR. LYONS: Objection, vague,	15	a seizure?
16	argumentative, calls for a legal conclusion.	16	A. Yes.
17	A. I have no idea what their relationship with	17	Q. Can a seizure cause a fatal arrhythmia?
18	the nurses is. I don't know if the nurses are employed	18	·
19	there, if they happened to show up and volunteer. I	19	A. I'm assuming that that's ultimately how one dies is the heart ultimately has to go into
20	•	20	
21	don't have any idea. I'm commenting on nurses' clinical	21	arrhythmia to quit working. Whether that causes it
22	behavior and a physician's clinical behavior, not	22	directly, I think it can sometimes be an asphyxiation
23	relationships with their employers.	23	type death.
	Q. (By Ms. Casas) Okay. Questions		Q. Do you know if Rachel Jackson had a history of
24	You said earlier you had treated patients	24	seizure?
25	that had brain cysts; is that correct?	23	A. She apparently did in childhood have a
	151		153
1	A. Sure.	1	seizure, I think.
2	Q. And did you already know they had a brain cyst	2	Q. And is that something that's common with
3	when you started treating them?	3	intracranial cysts or brain cysts?
4	A. There are not a huge number. At least a	4	A. I don't know the incidence of that.
5	couple of them, yes. One I was called by neurosurgery	5	Q. So you're not planning on giving any opinions
6	because we knew he had a cyst. Another one we got an	6	as to whether or not Travis County Jail's policy for the
7	MRI just because it was a first episode psychosis and	7	provision of medical care were constitutional or not
8	saw a cyst, and I called to neurosurgery to evaluate.	8	constitutional; are you?
9	They said: Leave it alone. Don't do anything.	9	A. No.
10	Q. And do you have any experience in neurology?		
11	A. There is limited training in neurology when		
12	we're in psychiatry residency and then in my year in		
13	internal medicine, but I'm not a neurologist.		
14	Q. The cyst Would a cyst in the brain that		
15	prevented parts of the brain from forming, such as the		
16	amygdala, would that be considered a primary central		
17	nervous system pathology?		
18	A. It's a It is a primary pathology likely,		
19	and it is in the central nervous system. That		
20	encompasses a whole wide variety of things, but it it		
	would fall into that umbrella, I suppose.		
21			
	Q. Do you have any experience in neurosurgery?		
22	, , , , , , , , , , , , , , , , , , , ,		
	Q. Do you have any experience in neurosurgery?A. No.Q. Okay. Are you Do you have experience in		

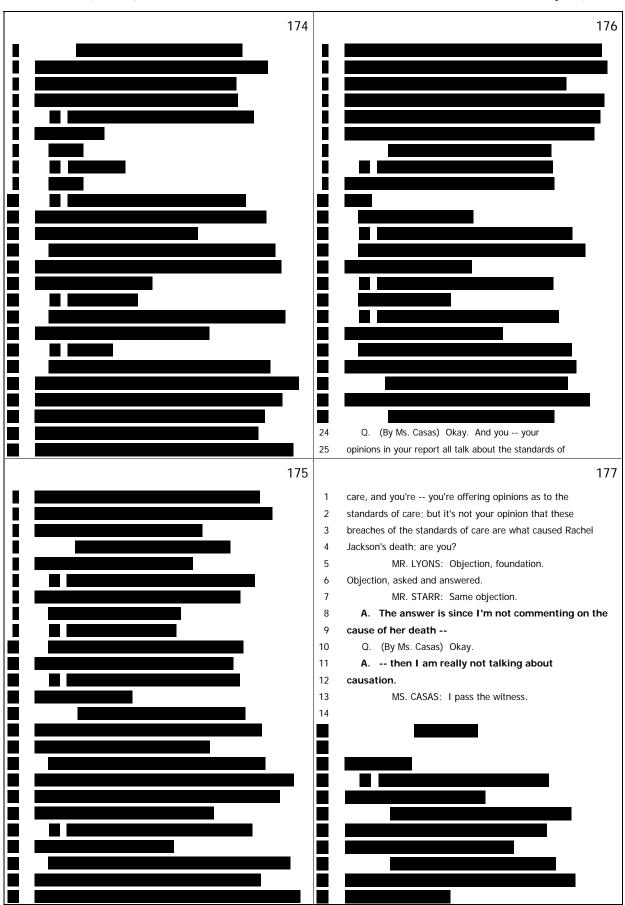


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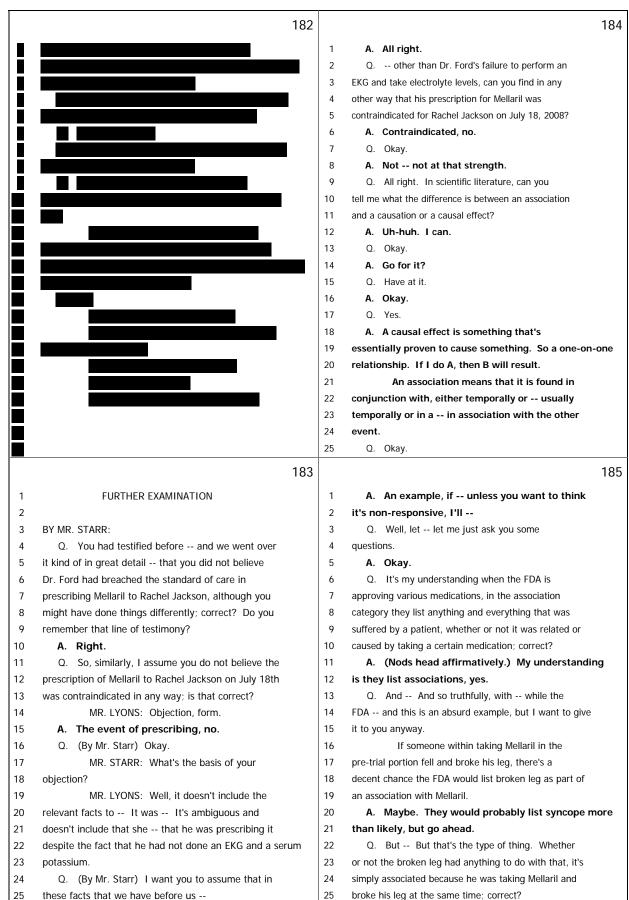
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44 (Pages 170 to 173) EXHIBIT F



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45 (Pages 174 to 177) EXHIBIT F



ł	186		188
1	A. Yeah, it might be.	1	Q. Based upon your review of that entire third
2	Q. And the Mellaril doesn't necessarily cause the	2	paragraph starting with the word "prolongation"
3	broken leg, and that's why they list it under	3	A. Uh-huh.
4	associated; correct?	4	Q is it your understanding that the
5	A. Yeah.	5	manufacturer of Mellaril, in conjunction with FDA
6	Q. Have you seen, either in this litigation or	6	approval, is stating that a causal relationship between
7	otherwise, the Novartis product literature for Mellaril?	7	arrhythmias and sudden death and Mellaril therapy has
8	And this is after the black box warning was introduced.	8	not been established but is possible?
9	A. Although I don't remember it looking like this	9	A. There are two steps. One step has been
10	I mean, I've seen it from pharmacists and like	10	established. The second one is only possibly
11	Q. And I have a I have a PDR version, as well,	11	established.
12	that	12	Q. Right.
13	A. Same thing. Uh-huh.	13	A. The first step is established.
14	Q looks similar if you want to see it.	14	Q. They're saying there is no causal relationship
15	A. Yeah. This looks like a PDR, something from	15	which has been established. Isn't that what the
16	of it.	16	manufacturer's literature says?
17	Q. Okay.	17	A. Between the events of presumably sudden
18	A. Yeah.	18	sudden death.
19	MR. STARR: Let's mark that as Exhibit	19	Q. Right.
20	No. 10.	20	A. It doesn't or it could be a torsades de
21	(Ray Exb. No. 10 was marked.)	21	pointe in sudden yeah, in sudden death.
22	Q. (By Mr. Starr) If you would turn to page 5 of	22	Q. And so do you read this particular paragraph
23	the manufacturer's literature.	23	and sentence to indicate that the manufacturer and the
24	A. Okay.	24	FDA do not believe there is a causal relationship
25	Q. And I'm looking at the third paragraph down	25	between taking Mellaril and fatal aris arrhythmias
	187		189
1	which starts with the word "prolongation."	1	and sudden death?
2	A. Right.	2	A. I don't know that the FDA particularly joins
3	Q. And the last sentence in that paragraph, could	3	in this part, this paragraph here. The FDA is the one
4	you read that out loud?	4	that dictates the black box warning.
5	A. It says, "A causal relationship between these	5	Q. Does the F Would the FDA allow Novartis or
6	events and Mellaril therapy has not been established;	6	the manufacturer of this material to print something
7	but, given the ability of Mellaril to prolong the QTc	7	that was not approved by the FDA?
8	interval, such a relationship is possible."	8	A. I don't know the answer to that entirely. I
9	Q. Okay. And I'm sorry. I should have had you	9	know they can require a black box warning, which is very
10	read you can read the top of that paragraph, but	10	clear. The rest of it, I don't know.
11	I'll I'll relate to you that what it's talking about	11	Q. You don't know whether a manufacturer can just
12	is sudden death.	12	write anything it wants, and it has no oversight
13	A. Uh-huh.	13	whatsoever in that product manufacturer literature by
14	Q. And so based upon your reading of this	14	the FDA? Is that your testimony?
15	paragraph, is it your understanding that both the	15	MR. LYONS: Objection, argumentative.
16	manufacturer and the FDA are saying that a causal	16	A. I don't know the answer to that. I know I
17	relationship between arrhythmias and sudden death with	17	know they can require a black box warning with specific
18	Mellaril therapy has not been established? Is that your	18	words in there. I've seen that.
19	understanding of what's set forth there?	19	Q. (By Mr. Starr) So at least and we'll take
20	A. I may be non-responsive, but the answer is	20	the FDA out. At least for the product literature, you
	partly.	21 22	have the manufacturer of Mellaril saying there is no
21	Q. Okay. And And let me ask it again	44	causal relationship between taking Mellaril and fatal
22		22	arrhythmias and sudden death: is that correct?
	A. Uh-huh.Q just so we kind of understand.	23 24	arrhythmias and sudden death; is that correct? A. Uh-huh. Or at least It says it's not been

	190		192
1	I'll go with that.	1	A. It depends. Sometimes it's reasonable. In
2	Q. Okay.	2	some cases it wouldn't be.
3	A. Uh-huh.	3	Q. What are the cases where it wouldn't be
4	Q. Mr. Lyons asked you earlier whether or not	4	reasonable?
5	We were talking about literature.	5	A. If you were trying to study, you know, maybe
6	A. Uh-huh.	6	an association effect that you weren't going to give
7	Q. He asked you whether you had reviewed the	7	them anything. If you were going to try to figure out,
8	three studies cited in the "Dear Doctor" letter; and I	8	for example, if being over 6 feet tall tended to
9	think you said: Yeah, I did a long time ago.	9	predispose you to cardiac arrhythmias, nine people
10	A. Back when it came out.	10	probably wouldn't do that.
11	Q. And	11	Q. Is it your opinion in this case that a sample
12	A. I'm sure I went and looked.	12	size of nine people in this article number one was
13	Q. And I believe you said that they discussed	13	sufficient to justify a peer-reviewed medical study?
14	arrhythmias caused by Mellaril?	14	A. Probably so. They actually took these guys
15	A. Yeah. That's my recollection. I haven't	15	and gave them new drugs.
16	looked at them in years.	16	Q. In number 1, the fact that these are healthy
17	Q. Okay. I I've got them here.	17	male subjects as compared to Rachel Jackson
18	A. Oh, good. Going to look at them again.	18	A. Uh-huh.
19	Q. And you can take as much time as you want.	19	Q in your mind, are there any
20	A. Okay.	20	distinguishments distinguishing characteristics to be
21	MR. LYONS: Let's attach them as exhibits	21	made there
22	as we show them to the witness, please.	22	A. Sure.
23	MR. STARR: We'll attach them as 11, 12	23	Q that we would expect different results
24	and 13.	24	because these are nine healthy males instead of Rachel
25	MR. LYONS: Let's take a	25	Jackson who is a not so healthy female?
	191		193
1	MR. STARR: Yeah. We can take	1	MR. LYONS: Objection, states facts not
2	MR. LYONS: Do you want to take a break	2	in evidence.
3	while she looks over it?	3	A. What you The reason that they picked nine
4	MR. STARR: a long break.	4	healthy males is that there aren't other confounding
5	THE VIDEOGRAPHER: Okay. We are off the	5	factors; and back when some of these were done,
6	record at 3:44 p.m. This concludes tape number 3.	6	typically you used male subjects because there wasn't
7	(Off the record from 3:44 - 3:55 and	7	also thought to be the confounding factor of hormones.
8	Ray Exb. Nos. 11 - 13 were marked.)	8	So frequently men were used back then. And it was
9	THE VIDEOGRAPHER: We are on the record	9	pretty typical to get some healthy usually youngish men
10	at 3:55 p.m. This is the beginning of tape 4.	10	so you wouldn't have other confounding factors that you
11	Q. (By Mr. Starr) Dr. Ray, I want to go quickly	11	might say: Oh, that's probably it.
12	over the three articles. And you have now had the time	12	So the things that you would expect to be
13	to review them	13	different are that people who are sicker or who have
14	A. I have.	14	other drugs in their system or who have other are
15	Q to the extent you want to.	15	older would have more confounding factors and less
16	Exhibit 11 is what I will refer to as	16	clear results and be more likely to have health effects.
17	article number one.	17	Q. Okay. And what were the findings of article
18	A. Okay.	18	number one?
19	Q. And it's my understanding that medical article	19	A. The findings of I'm sorry. What was the
20	consisted of a study size of nine healthy male subjects;	20	last part?
21	is that correct?	21	Q. I'm sorry. Of article number one.
22	A. Right.	22	A. Of article number one.
23	Q. And in the scientific community, is that	23	Q. Exhibit 11.
24	typical to to base peer-reviewed opinions upon a	24	A. Basically, it says that Mellaril or
25	study size of only nine people?	25	thioridazine has dose-related effects on ventricular

	194		196
1	repolarization oh, sorry thioridazine has dose	1	death. We can't say that it caused a fatal arrhythmia.
2	related effects on ventricular repolarization. The	2	We can say it caused an arrhythmia which can be fatal.
3	parent drug, meaning the thioridazine itself, causes an	3	Q. In some people.
4	important portion of these effects, although metabolites	4	A. Right.
5	also contribute.	5	Q. Okay. Exhibit No. 12.
6	Q. And does it quantify to the extent it	6	A. Okay.
7	claims that Mellaril increases the prolonged QTc	7	Q. And I will refer you to or I'll maybe just
8	interval, does it quantify them in these nine people on	8	read from I don't know if it's in here.
9	average?	9	The FDA letter indicates that this second
10	A. Yeah. Let's see. The mean QTc was increased	10	study studied increased levels of thioridazine in
11	from 388 to 411.	11	patients with a genetic defect resulting in slow
12	Q. Which would be	12	hydroxylation of debrisoquin.
13	A. Let's see, that's Wait a minute. Hold on.	13	A. Uh-huh. That's good.
14	I'm looking for the dosage of that one. That was	14	Q. Does that have anything to do with Rachel
15	That was the 50 milligram dose.	15	Jackson?
16	Q. So in that study they found on average a	16	A. Not that we know of.
17	approximately 5 percent increase, 5 to 6 percent	17	Q. We don't know that she had a genetic defect
18	increase in the QTc level?	18	A. Right.
19	A. I need to do the math. It's from 388 to 411.	19	Q such as studied in this case; correct?
20	So 12 23.	20	
21		21	A. Right.
22	Q. And, again Okay. In your review of	22	Q. And so can we glean anything from this case?
	Exhibit 11, is it a true statement no one died, at least	23	A. No. This is just talking about other things
23	from what you can tell?		that might contribute to thioridazine being more toxic.
24 25	A. Not that they reported, no one died.Q. No No one had sudden death or pointe de so	24	Q. And But it is not relevant to her case
	195	120	because she didn't have that genetic defect as far as
1	or whatever the arrhythmias are?	1	you know.
2	A. Torsades de pointe.	2	A. As far as we know, that's true.
3	•	3	Q. Okay.
	Q. Torsades de pointe.	4	A. Uh-huh.
4	A. Uh-huh. Yeah. Right.	5	
5	Q. And so we cannot look at Exhibit 11 and say		Q. And, finally, Exhibit
6	the use of Mellaril causes fatal arrhythmia or sudden	6	A. 13.
7	death. Is that a correct statement?	7	Q 13
8	A. You can't say that it caused that it has	8	A. Uh-huh.
9	a a direct cause by this article. You can say that	9	Q was a study which evaluated the effect of a
10	it prolongs the QTc interval which can be associated	10	drug called fluvoxamine
11	with death. We know that.	11	A. Uh-huh.
12	MR. STARR: I'll object as	12	Q on thioridazine levels.
13	non-responsive.	13	A. Right.
14	Q. (By Mr. Starr) My question was a little	14	Q. And as far as we know, Rachel Jackson did not
15	different.	15	take fluvoxamine; correct?
16	A. Okay.	16	A. Right.
17	Q. Just in reviewing this article of the	17	Q. And so, once again, article number three
18	subjects, none of them died.	18	relied upon in the FDA letter would be completely
19	A. Right.	19	irrelevant to Rachel Jackson's case.
20	Q. None of them had fatal arrhythmias.	20	A. Well, what I haven't looked at is because I
21	A. They had arrhythmias. None of them fatal.	21	think they at least measure plasma levels before giving
22	Q. And so as a result of this article, we cannot	22	the fluvoxamine.
23	say, nor could anyone say, that this proves Mellaril	23	Yeah. The focus of this article really
24	causes fatal arrhythmias or sudden death?	24	is on fluvoxamine prolonging the higher blood levels.
25	A. We can't say from here that it causes sudden	25	Q. Okay. Since she wasn't taking fluvoxamine, it

50 (Pages 194 to 197)

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1 really doesn't help us too much; is that correct? 1 the difference in medical term	
,	ninology between an
2 A. That part doesn't. I was just looking to see 2 absolute contraindication and	-
3 if they measured QTc intervals on thioridazine as 3 contraindication. Do you reca	all that testimony?
4 monotherapy. 4 A. Yeah.	,
5 Yeah, I don't see it. Just in perusing 5 Q. And are you familiar w	with those two terms.
6 it right now, I don't see anything that's relevant to 6 separate and apart from Dr. F	
7 that. It may be in here, but I don't see it. But the 7 A. Yes.	,
8 focus of the study, you're right, is on fluvoxamine 8 Q. Can you tell me what	a relative
9 inhibiting the metabolism of thioridazine . 9 contraindication is?	
10 Q. And out So out of the three studies cited 10 A. A relative contraind	dication means that it's
	ould not be done. There may be
	al circumstances that might
13 A. Uh-huh. 13 permit it to be done.	-
14 Q had any relevance to this case; is that 14 Q. What's an absolute co	ontraindication?
15 correct? 15 A. It should not be dor	
16 A. Any direct relevance, yeah, as far as we know. 16 Q. Is it your opinion that	
17 Q. And and that Exhibit 11, article one, 17 Well, let me show you.	Freezening menen
18 nobody died and we're not really able to correlate a 18 Actually, do you ha	ave that Novartis
19 what did we say a 20 percent increase in QTc 19 literature?	
20 prolongation with percent chance of death; is that 20 A. Yeah. There you go	o.
21 correct? 21 Q. Yeah. If you will turn	
22 A. In this In this article, no, because no 22 paragraph down that begins v	
23 one died; but we know what we do know is that it can 23 A. Uh-huh.	
24 be a fatal arrhythmia, and that's why the concern. 24 Q. Why don't you read the	hrough that guickly?
25 MR. STARR: I'll object to the 25 A. Do you want me to	
199	201
1 non-responsive portion. 1 Q. No, no. 2 Q. (By Mr. Starr) No one in article 11 or 2 A. Oh.	
3 article one, Exhibit 11, had a fatal arrhythmia; 3 Q. Just let you read i	
4 correct? 4 A. (Witness compli	, ,
	paragraph down indicates:
	patients being considered for
	baseline ECG performed and
	neasured." Is that Did I
10 correct? 10 A. You did.	us that contains to define the
	ve that sentence to define the
12 Q. Okay. 12 standard of care for what 13 A. So whatever that is. 13 in this particular case?	you believe Dr. Ford breached
· ·	at sentence defines it. I
14 Q. Have you seen any articles or seen any studies 15 which discuss how large a prolongation is necessary in 15 think it reflects it.	at sentence defines it. I
	opinion it is an absolute
	•
	G and taking serum potassium
19 arrhythmia is. Let me put it that way. 19 levels?	o and taking scruin potassiuili
	efore, it's not absolute.
21 say what number we need to reach where 95 percent of 21 It's a pretty strong relationship.	
	ord similarly testified he
	ve contraindication. Is that
24 cardiology. I don't know. 24 your recollection?	5 55 amanadation. 15 tilat
25 Q. Okay. In his deposition Dr. Ford discussed 25 A. Yeah, that he sa	nid so. Uh-huh.

	202		204
1	Q. And would you agree that a relative	1	Q. Okay.
2	contraindication, part of what goes into that is that a	2	A. But Geodon, yes, within the past year.
3	physician being aware of potential warnings needs to	3	Q. And as well as other medications which have
4	weigh the risks and benefits of prescribing certain	4	I mean, I assume every medication has warnings and
5	medication for an individual patient?	5	cautions in some form or another.
6	A. Of course.	6	A. At least adverse reactions or something like
7	Q. And is that what you believe Dr. Ford did in	7	that, yes.
8	this case?	8	Q. And in each case I assume you go about the
9	A. Do I believe he weighed them? I'm assuming he	9	process of being aware of those warnings but then
10	did.	10	weighing the risks and benefits for each individualized
11	Q. And he testified he was aware that this	11	patient.
12	warning was out there and, yet, in Rachel Jackson's	12	A. Sure.
13	particular case, he thought it was still in her best	13	Q. And sometimes, despite that, despite you
14	interest to give her Mellaril. Is that your	14	weighing the risk and benefits of for that individual
15	understanding?	15	patient, sometimes bad outcomes result even when you
16	A. What he seemed more to say was that he just	16	that weighed it all; is that true?
17	thought those warnings were overly cautious. He didn't	17	A. Yes.
18	say specifically about her.	18	Q. Would you agree with the statement: Bad
19	Q. Do you believe and and I think you may	19	outcomes can happen to the patient even when there is no
20	have already answered this about absolute; but in this	20	breach of the standard of care?
21	sentence in the manufacturer's recommendation where it	21	A. Sure.
22	says "It is recommended" that patients get an ECG and	22	Q. Simply because a bad outcome results to a
23	serum potassium level, you do not equate "It is	23	patient does not mean a doctor has disregarded a
24	recommended" with "doctors must."	24	substantial risk.
25	A. There is no "must" in there because there	25	A. That's true.
	203		205
1	might be some circumstance in which it would be	1	Q. Okay. In fact, would you agree that if a
2	appropriate not to do that, but I don't think that's the	2	doctor actually weighs is aware of the risks, is
3	case here. That's	3	aware of the benefits and weighs those risks and
4	MR. STARR: And I'll object to the	4	benefits, he is actually not disregarding those risks,
5	non-responsive portion.	5	by definition.
6	A. Okay.	6	A. I think if he is aware of the risks and weighs
7	Q. (By Mr. Starr) Are there circumstances where	7	them for that particular patient and decides on it, then
8	either the FDA or medical pharmaceutical manufacturers	8	he's then he is yeah, then he's looked at the
9	use the word "must"? You must not do this or else the	9	risks and examined them.
10	patient's going to die.	10	Q. Okay. You have no information, based upon
11	A. There are a few. Most of those are regulated	11	what you have read, no opinion, that Dr. Ford did
12	in some other way by the FDA.	12	anything to intentionally injure Ms. Jackson.
13	Q. Okay. And those would be our absolute	13	A. I would hope not.
14	contraindications.	14	Q. And that's not your opinion?
15	A. Yeah. The FDA just doesn't approve their use.	15	A. No.
16	Q. Okay. Dr. Ford identified various	16	Q. And, similarly, are you of the opinion
17	medications Mellaril being one, Geodon being	17	Dr. Ford did anything to that he had malice in his
18	another that have warnings that every doctor knows	18	heart and he was maliciously trying to injure her?
19	about, every psychiatrist knows about and, yet,	19	A. I have no evidence at all of that.
20	psychiatrists still prescribe those medications. And,	20	Q. I hate to harp on this, but I want to go back
21	in fact, you have testified you have prescribed Mellaril	21	one more time and ask you about issues involving your
22	within the last year.	22	litigation experience.
23	Have you prescribed Geodon within the	23	A. Uh-huh.
24	last year?	24	Q. You are obviously charging \$600 an hour for
25	A. The Mellaril was was a year or more ago.	25	this case; correct?

	206		208
1	A. Right.	1	A. Some weeks and other weeks there's none.
2	Q. Does that money go to you or to Methodist	2	Q at at \$600 a week \$600 an hour
3	Hospital?	3	A. Yeah.
4	A. Me.	4	Q we're looking at 3,000 to 6,000 a week in
5	Q. In all of the cases that you have that you are	5	litigation; correct?
6	reviewing in a given year, 25 20 to 25 in a given	6	A. It's not that much. I wish it were, but it's
7	year	7	not that much.
8	A. Uh-huh.	8	Q. Okay. So you think it's less than five to ten
9	Q do you charge \$600 per hour in each of	9	hours a week?
10	those cases?	10	A. Average, it might be five hours a week, maybe.
11	A. Yes.	11	But I know it's not that much a week.
12	Q. And how long has that been the case?	12	Q. So in any given week, approximately 3,000 or
13	A. I think my my office manager raised my fees	13	more dollars per week made doing litigation work?
14	last year, maybe.	14	A. (Nods head affirmatively.) Maybe. Yeah.
15	Q. And	15	Q. So up to \$150,000 or more every year doing
16	A. Oh, and by the way, that's not entirely true.	16	litigation?
17	There's been an indication when I have agreed to do a	17	A. Oh, that would be nice. I don't think that's
18	case that is particularly interesting at a different	18	right either. I really can't tell you. I mean, some
19	fee. I think the one with the Attorney General's Office	19	years probably so.
20	may have been, for example; but it's pretty rare.	20	Q. Okay. Some years more than that, some years
21	Q. You said that you are currently doing 20 to 25	21	less than that?
22	case a year. How long or I'm sorry. You're	22	MR. LYONS: Objection, form.
23	reviewing that many.	23	A. I'm not sure if any year I've made more than
24	A. Uh-huh.	24	that in forensic work.
25	Q. How long has been the case?	25	MR. STARR: I'll pass the witness.
	207		209
1	A. That's hard to say because it fluctuates so	1	FURTHER EXAMINATION
2	much. You know, a number of them I turn down when the	2	
3	review is you know, it may take me a half hour to	3	BY MS. CASAS:
4	review it and say: "Nope. Sorry. I don't want to do	4	Q. Dr. Ray, I just have a couple questions. I
5	it," or "I don't think you've got a case." So I	5	touched on it last time, but I want to make sure I get
6	don't It's hard for me to say.	6	an answer to this specific question.
7	Q. Do you have any way to gauge for us what	7	A. Okay.
8	percentage of your income is based upon litigation	8	Q. Do you believe you have training and
9	versus the practice of medicine?	9	experience enough training and experience in pharmacy
10	A. That's pretty hard. I can I can estimate	10	or pharmacology to offer an opinion on the actions of a
11	my time, and I guess we can figure it out maybe from	11	pharmacist?
12	that. I'd say probably 10 percent of my time, maybe 15	12	A. I suppose in only a very limited way; and that
13	percent in a busy year, is forensic stuff; and that fee	13	is that if they're if the hospital rules, for
14	is about twice what I charge in my office.	14	example, require them to notify me of something and they
15	Q. And I think you said and I want to make	15	don't do it
16	sure I get this right.	16	Q. Okay.
17	A. Uh-huh.	17	A I can say that falls below the hospital
18	Q. I think earlier you said you probably spend	18	standards.
19	five to ten hours a week doing litigation; is that	19	Q. Okay.
20	correct?	20	A. In terms of the training, stuff like that, no.
21	A. Doing forensic psychiatry, which is mostly	21	Q. Okay. And do I think I did ask you, but
22	going to be litigation or I guess when I was teaching	22	you don't intend to offer an opinion as to the actions
23	more, it included that, too.	23	of the pharmacist in this case; do you?
24	Q. And so if we assume, we'll say, five to ten	24	A. No.
25	hours a week	25	Q. Do you intend to offer any testimony as to the